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Introducing out-of-pocket payment for General Practice in Denmark: Feasibility and support☆

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ABSTRACT

Aims: The financing of General Practice (GP) is a much-debated topic. In spite of out-of-pocket (OOP) payment for other primary health care provided by self-employed professionals, there is no OOP payment for the use of GP in Denmark. This article aims to explore the arguments, the actors and the decision-making context.
Methods and materials: An analysis of the healthcare-policy debate in Parliament and the media from 1990 until September 2012. The materials are parliamentary hearings/discussions and newspaper articles. Kingdon's model on Policy Windows and the Advocacy Coalition framework by Sabatier and Jenkins are used to investigate explanations.
Results: The arguments from the proponents are: that OOP payment for GP will reduce pressure on the primary sector; that the current allocation of OOP payment in the sector is historically conditioned; and that resistance towards OOP payment is based on emotions. The main argument from the opponents is that OOP payment will increase social inequality in health.
Conclusions: There is little connection between the attitudes and ideological backgrounds of the political parties. Despite factors such as perceived expert/scientific evidence for OOP payment, changes of government, financial crisis and a market-based reform wave, no government has introduced OOP payment for GP. This article suggests that governmental positions, public- and especially health-professional support are important factors in the decision-making context.

1. Introduction

Out-of-pocket payment in the healthcare sector is a much-debated topic internationally, and also in Denmark. What separates Denmark from several countries, even other Scandinavian countries [1:19,2:62], is that there is no out-of-pocket payment for the use of general practitioners. Instead, the GPs are reimbursed by the Danish regions via a combination of capitation and fee-for-service [3:80]. GPs have been financed via taxes since 1973, when the predecessors of the Danish regions, the counties, took over the 'insurance schemes' [3:31] existing at that time. Other services provided by self-employed professionals (except private practicing specialists if referred to by the GP) in the primary sector are subject to OOP payment[1], which makes the public financing of GPs even

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[1] Physiotherapists, dentists, chiropractors, psychologists and pharmacies.

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more interesting. However, the GPs do hold a special role in the Danish health care system, as they act as gatekeepers to all other services. There is no logical pattern determining whether a specific service is paid for by the patient or the region/municipality [3:63–4]. Denmark has undergone extensive market rationale-based health sector reforms during the past decades [4:44–5], but no steps have been taken towards changing the financing of GP. Finally, Denmark had a liberal–conservative government in 2001–2011 that could be expected to favour OOP payment for GP because this potentially leads to lower taxes and is based on market mechanisms. From the above it appears that the GP area is 'resistant' to international influence and the general marketisation of other parts of the healthcare system. The question is *why* this is the case?

International peer-reviewed literature about OOP payment for GP has a financial and behavioural perspective that focuses solely on the consequences of OOP payment: *will* OOP payment reduce the use of public services and therefore have the potential to reduce the overall expenses? *Will* there be any healthcare consequences of OOP payment? *Will* OOP payment reduce the use by some groups of the population more than by others? [5–21]. The purpose of this article is *not* to make conclusions about the effects of OOP payment, but to investigate and discuss the actors, arguments and the decision-making context in the health care policy debate in order to provide insight into why OOP payment for GP is introduced or not. This will be done via a systematic analysis of the media debate from 1990 to 2012 and by drawing on Kingdon's theory about policy windows [22] and Sabatier and Jenkins advocacy coalition framework [23,24]. The findings will be of relevance to policy analysis in other high-income countries where the health care financing structure and political system are similar (for example, England, Norway, Sweden etc.), as this creates better grounds for comparison and transferability. In the following, I will argue that the financing of the GP in Denmark is not dependent on the political parties' ideological backgrounds (which seems to be the general notion in the debate) but is a question of political feasibility and especially the support of health professionals and the public.

2. Methods and materials

The arguments in the healthcare-policy debate have been identified via a systematic analysis of media and parliamentary debates from 1990 until September 2012. This period of time was chosen due to an increase in the discussion in the media, and because this was the prime time for market-based reforms of the healthcare sector [4:44–5].

Data from the parliamentary debates was found via a search on the website of the Danish Parliament: www.folketinget.dk. The search was limited to documents under the 'Parliamentary Health Committee' [Sundheds og forebyggelsesudvalget], 'Parliamentary Finance Committee' [Finansudvalget] and 'Parliamentary Social Committee' [Socialudvalget]. These committees consider decisions about OOP payment for GP. The search terms were 'out-of-pocket payment' [brugerbetaling] and 'doctor' [læge]. Three hearings/discussions included explicit discussion of OOP payment for GP. Data from the media debate was found via a search in the Danish media database *Infomedia*. The search strategy included the following search terms: 'healthcare system [sundhedsvæsen] or health [sundhed] and out-of-pocket payment [brugerbetaling]'. All national newspapers and magazines were included because the entire political spectrum was to be covered. Local newspapers were not included, as this would be too extensive. In addition, legislation and decision-making about OOP payment take place at national level [3:70] and the main points would therefore be included in the national search. Opinion articles and contributions to the debate from individuals without political or expert status were not included, because it was expected that the main political points and arguments would be included in the political/expert search. Twelve newspapers and magazines[2] were included in the search and 1415 articles were found. The main criterion for selection was that the article discussed OOP payment for General Practice directly and contained arguments. The selection process resulted in 103 relevant articles.

The arguments were categorised into argument clusters, which is to be understood as a collection of minor arguments categorised under a single argument covering them all. This was done so as to create order and an overview of the debate.

3. Theoretical frame

The results were investigated by using Kingdon's three streams and policy windows and Jenkins' and Sabatier's advocacy coalition framework. Kingdon operates with policy windows, which are likely opportunities for policy change. A policy window opens when the problem stream (identification of problems), the policy stream (identification of solutions (feasibility and support)), and the politics stream (situational factors such as changes of government, campaigns, swings of national moods, etc.) run together [22]. The advocacy coalition framework focuses on the interactions between opposing advocacy coalitions (actors from a variety of positions who share a particular belief system [24:139]), the analysis of factors explaining policy change, and the explication of belief systems of opposing coalitions in which the characteristics of the policy context lie [23:266–7]. Inhibitors for cross-coalition learning (agreement) are identified as: intense conflict where neither coalition is willing to modify its belief system, if the issue is highly analytically intractable (especially where objects of the analysis are themselves advocates in the debate), and if the issue is addressed in an open political forum where the participants are highly heterogeneous [23:270]. Despite the focus on belief systems, Sabatier points out that even though the belief system determines the direction in which the advocacy coalition moves, its ability to move will be critically dependent upon

[2] *Aktuelt, Berlingske, BT, Ekstra-Bladet, Jyllands-Posten, Kristeligt Dagblad, Politiken, Weekendavisen, Mandag Morgen, Ugeskrift for læger (the Journal of the Danish Medical Association), Altinget, Information.*

its resources (money, expertise, number of supporters and legal authorities) [24:147].

4. The debate

The debate about the financing of GPs was ongoing throughout the entire study period and began before 1990. The debate increased from 2003 to 2007 and from 2009 to 2012. The analysis shows that there is variation in the consistency of attitudes between political parties, interest groups and experts. Where some political parties change their attitude over time, interest groups, experts and the general public maintain their respective attitudes. Fig. 1 is an illustration of the party-political attitudes towards OOP payment for GP.

The left-wing party (the Socialist People's Party), the far left-wing party (the Unity List) and the neoliberal party (the Liberal Alliance)[3] [25–33] act in accordance with their respective ideological backgrounds. The conservative (Conservative Party [26,28,34–37]) and social-conservative (the Danish People's Party [26,27,36]) parties do the opposite, as they reject OOP for GP[4]. The Social Liberal Party changed its position in 2006 in both the parliamentary and media debates, proposing a *potential* re-allocation of OOP in the healthcare sector based on evidence [26,27,38,39] (hence the shape of the arrow). The two largest parties in Denmark, the Liberal Party and the Social Democratic Party, which are presumably for and against OOP payment for GP, respectively, changed their attitudes over time. From the beginning of the 1990s until 2011 the Liberal Party declared that it was against OOP payment for GP [26,29,35,38,40–43], but changed its attitude after becoming part of the opposition in 2011. The Social Democratic Party politicians were originally against OOP payment in the 1990s [41,44], but from 2006 and onwards the party has been more open to a possible change in the allocation of OOP payment in the healthcare sector [36,38,45,46]. In 2011, however, after coming back into government, the Social Democratic Party reverted to its original negative attitude [26,29,31,47]. The figure shows inconsistency between the presumed attitudes based on ideology and the attitudes articulated in the debate. This could imply that the attitudes towards OOP payment for GP do not depend entirely on ideological background but that other factors such as feasibility, support and coalitions could be of importance. This will be investigated further after the content of the arguments has been elaborated.

4.1. The content of the arguments

In the debate, the arguments are stable through all years. The only aspect that changes is which players align themselves with the arguments. For this reason, the following section will elaborate the identified clusters of argumentation. The analysis shows that the content of the policy discussion in the media and in parliamentary debates can be divided into four clusters: (1) the introduction of OOP payment for GP will reduce the pressure on the primary healthcare sector; (2) the current allocation of OOP payment is historically conditioned and not rational; (3) resistance towards OOP payment for GP is emotionally-based politics; and (4) OOP payment for GP will lead to increased social inequality in healthcare. Proposers of OOP payment, who dominate the debate, hold the first three cluster arguments, while the opponents hold the fourth.

4.1.1. "Reduction of use of General Practice"

It is a prevalent argument that introducing OOP payment for GP will reduce the number of visits to general practitioners [28,42,44,48–57]. Proponents argue that people will '*think about it one more time*' before consulting their GP [55,56,58]. Embedded in this argument is an understanding and distinction of GP visits as being either necessary or unnecessary. Proponents argue that the unnecessary visits will be reduced [54,59,60]. Opponents such as the Organisation of General Practitioners in Denmark[5] and the Danish Medical Association[6] argue that unnecessary visits do not exist [41,61], because the visit will only be seen as unnecessary *after* the consultation [61]. There is a notion in the debate that money will be saved if people consult their GPs less often [41]. However, the Chairman of the Danish Medical Association contests this by arguing that there will be no financial benefit if the elderly, the chronically ill and children are not subject to OOP payment, as these groups use their GPs the most [41].

4.1.2. "Historically-conditioned allocation of OOP (not rational)"

The most prevalent argument in the debate is that the allocation of OOP payment in the healthcare sector is based on historical coincidence [26,32,38,44,48,50,56,57,62–89]. This appeared for the first time in 1995 and has been extremely prevalent ever since and was used increasingly in 2010–2012. There is broad political and expert agreement that the historically conditioned allocation of OOP payment is a problem. The high element of OOP payment for dental care is identified as a particular example of injustice [26,38,44,56,57,67,68]. All of the individual 'experts' that appear in the media are health economists and in favour of (some) OOP payment for GP [28,35,36,38,43,46,65,68,69,90–92]. The experts and their support for OOP payment for GP are supported by reports published during the period of the study by the Danish Institute for Health Services Research [93] in 1995; the Welfare Commission in 2005 [94]; the OECD in 2008 [95]; and most recently by the Danish Institute of Governmental Research (AKF) in 2012 [96]. There are three solutions attached to the problem: to remove all OOP payment in the healthcare sector [30,97]; to allow

[3] Established in 2007.

[4] The conservative was for OOP payment for GP in a small time-period at the end of their Government period in 2011.

[5] The organisation of general practitioners in Denmark is a subdivision of the Danish Medical Association and focuses on the professional and financial interests of general practitioners.

[6] The Danish Medical Association is a an organisation for Danish doctors and is recognised by Parliament, the Danish Health and Medicines Authority, the ministries, and the private sector as an expert and advisory body on medical questions [44].

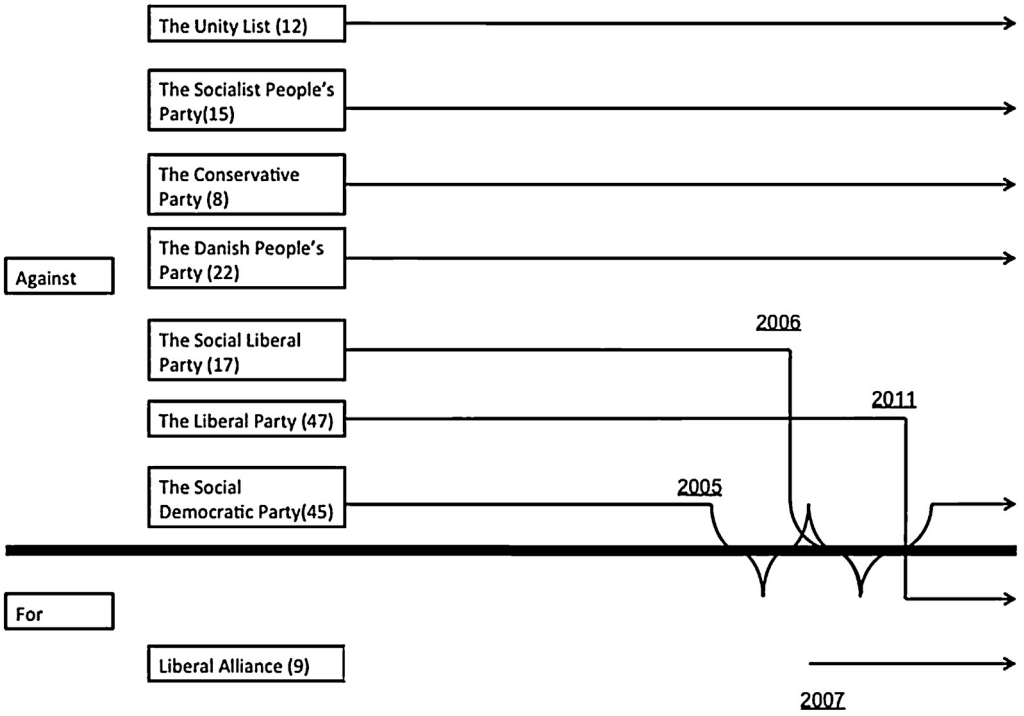

Fig. 1. Political parties and attitudes towards OOP payment for GP (no. of parliamentary seats in brackets).

the current system to remain [32,58,89,98]; or to re-allocate OOP payment by introducing OOP payment for GPs while reducing the proportion for other healthcare services [26,38,44,48,50,56,57,62–89,98]. Most actors argue in favour of re-allocating OOP payment, thereby introducing OOP payment for GP.

4.1.3. "Resistance to OOP is emotionally-based politics"

Proponents argue and criticize that resistance to OOP payment is based on emotions. The primary argument is that OOP payment for GP is a political taboo [29,37,42,49,50,55,56,58,64,79,89,99–108]. The argument appears in the years 2006, 2008 and 2011. This aspect should be viewed in conjunction with the fact that discussions of OOP payment for GP increased in the years just before or while OOP payment was articulated as a taboo. In the argument, metaphors from war and religion are used [42,64,99,101,106–109]. Via the argumentation, the lack of OOP payment is presented as being equivalent to religion, which implies that the resistance is based on emotions rather than logic. Additionally, it is argued that politicians are '*scared*' of introducing OOP payment, due to the expected reduced electoral support [37,50,79,99,108,110]. Furthermore, the resistance is identified as being automatic and non-reflective via such metaphors as '*automatic gun*' and '*spinal reflexes*' [100,102,105].

4.1.4. Increase in social inequality in health

Opponents, especially the doctors' unions, but also political parties, argue that OOP payment for GP will lead to a deterioration in health care for certain groups [30,33,36,41,58,89,106,111–114]. The argument appears several times in 1991, 1995 and especially in 2002–2003, 2008 and 2011. The most consistent opponents of OOP payment for GP are the Organisation of General Practitioners in Denmark (PLO) [29,36,40,41,61,65,115–117], the Danish Medical Association [31,38,41,90,118] and patient organisations [57,113]. The doctors' unions follow the social inequality argument, focusing on patient rights in particular [115,118].

In the debate it is argued that the current free access to the GP and healthcare system is both a value in itself [41,58,89,111,119] *and* a contributor to the reduction of social inequality [30,41,89,111,114,120]. On investigating the argument it is interesting that there is no clear definition of *who* is defined as the vulnerable groups. In the debate, the definitions appear to be based on either the extent that GPs' services are used (the elderly, the chronically ill and children) [41,111]; social status (the unemployed and the elderly) [33,41]; health status (the elderly, the chronically ill) [36]; or economic status (single mothers, immigrants and people with little education) [112]. The doctors' unions use a combination of the weak-group definitions: low income and chronically ill [36,40,61,116–118].

Both opponents and proponents agree that an increase in social inequality in health care is not favourable, but they have different solutions. Opponents completely reject OOP payment as a solution, due to the possible increase in social inequality, while proponents modify their proposal by drawing on the existence of OOP payment for GP in the other Nordic countries [26,28,31,34,42,44,46,50,52,55,57–60,41,62,66,69,79,80,92,107,109,

112,121–128] combined with the payment ceilings applied in order to reduce the expected social inequality [26,69,98]. For example: '*people aren't lying dead in the streets in Norway and Sweden, even though they have introduced a limited user payment*' [55]. Further evidence from the opponents regarding OOP payment and social inequality is based on the dental care experience in Denmark, as it is the general belief that the existing OOP payment contributes to social inequality in dental healthcare [97,112,115].

For the general population, an analysis performed in 2011 by the Centre for Alternative Social Analysis shows that 73% of the population is against OOP payment for General Practice. Only 14% believe that there should be an income-related OOP payment; 13% believe in a fixed amount; and only 1% of the population believe in full OOP payment [129]. The fact that the majority of the population is against OOP payment is backed up by minor surveys conducted by various newspapers [29,37,110].

5. Policy windows and advocacy coalitions

The results show that ideology does not seem to be essential for determining the politicians' official attitudes towards OOP payment in Denmark. Thereby not said that ideology cannot have an influence on non-official attitudes, as these could differ from the official attitudes—due to for example coalitions and compromises between parties. Only some parties have an attitude in line with their ideological background, and three out of eight parties change attitude during the period of the study. Ideology does however seem to be evident in terms of the arguments as the for-OOP payment arguments focus on cost-control, efficiency and rationality, while the against-OOP payment argument focuses on social inequality. In the following, the results will be discussed using the Kingdon and the advocacy coalition frameworks.

The problem stream in this debate involves the articulated over-use and unnecessary visits to general practitioners, which put pressure on the primary sector in terms of both human and financial resources. Additionally, the historical allocation of OOP payment in the Danish healthcare sector is problematised. As shown, both proponents and opponents agree that it is problematic that there is no logic behind the allocation in the healthcare sector. This means that it is an acknowledged claim in the debate that the current allocation of OOP payment is problematic. With regards to the *politics stream* or *situational factors*, there have been external changes that presumably would advocate a policy change in order to introduce OOP payment for GP. Examples are a liberal–conservative government from 2001 to 2011 as well as the onset of the financial crisis in 2008, which has even further limited increased use of public resources. This means that the problem stream and the politics stream run together. As for the *policy stream*, several solutions are proposed—also taking social inequality into account. The policy stream, however, also includes elements such as feasibility and support. It is *legislatively* feasible for the government to change the allocation of OOP payment in the healthcare sector and to introduce OOP payment for GP visits [3:70], but this requires a political majority in favour. As the analysis showed, only Liberal Alliance is consistently in favour of OOP payment for GP, and the Liberal Alliance only holds nine parliamentary seats. The Liberal Alliance cooperates with the Liberal Party, the Conservative Party and the Danish People's Party, who all were against OOP payment for GP during their time in government. The Liberal Party has only recently changed attitude after becoming opposition, and is now in favour of OOP payment. The Social Liberal Party has been open for discussions about changing OOP payment allocation in the healthcare sector since 2005 – as has the Social Democratic Party since 2006 – but after forming a government (together with the Social Liberal Party and the Socialist People's Party, and with the support of the Unity List) the latter is now fully against OOP payment for GP.

The changing attitudes implies that this is not a topic where the resistance towards changing the belief systems is strong, which in terms of the advocacy coalition framework implies that the likelihood of cross-coalition agreement should be relatively high. However, it seems as if the attitudes change after parties win or lose governmental power; it appears that no party in government wishes to change the financing of General Practice. The analysis showed that the most consistent opponents of OOP payment for GP are the doctors' unions, i.e., the general practitioners themselves. In the advocacy coalition framework it is stressed that an inhibitor for cross-coalition learning is when the policy object is analytically intractable. Furthermore, social policies where the advocates in the debate are objects of the debate themselves are mentioned as an example. This creates, if following the advocacy coalition framework, a hostile policy context, where agreement is difficult, which seems to be the case in this matter. Additionally, there appears to be a low degree of public support. This means that neither the (private) employees nor the public support the introduction of OOP payment for GP, which makes it less likely that a government would risk the unpopularity of introducing OOP payment for GP. As Sabatier and Jenkins point out: the belief system may determine the direction but the ability to move depends on support. Also, an inhibitor for agreement in this case can be considered to be the heterogeneous (politicians, interest groups, experts) debate forum, as the advocacy coalition framework states.

6. Discussion

Debates and discussions about the financing of the health sector are not only relevant in Denmark but also on an international level as discussions on how to finance health care services appear in all countries. The findings in this study are, however, mostly relevant to other high-income countries with similar financing structures and political systems, as the common features increase the transferability. The previous financial and behaviourally oriented literature about OOP payment has not been able to explain why OOP payment has been introduced but focuses merely on the effects of OOP payment for GP. This systematic analysis of the parliamentary and media debate on the topic therefore contributes with new knowledge. Furthermore, the findings contradict the general (not

scientifically proven) assumption that the financing of GP is a matter of ideology. Institutional, ideological and decision-making perspectives are all combined in the study, which ensure that several angles of the issue are investigated.

There are limitations to this study. By only choosing national newspapers and magazines, arguments have potentially been missed. It is, though, the belief that all relevant arguments for the area are recorded in national media. The inclusion of all national newspapers, as well as the period of 22 years, should ensure that all relevant documentation is included and that changes in the debate are identified, in order to investigate the research question. However, further evidence, such as interviews with civil servants, politicians and representatives for the interest groups, would potentially have strengthened the evidence and insights of the findings. Additionally, it is a limitation that only few surveys of the general population's attitudes exist. However, as this article investigates the political decision-making, the important aspect is what the politicians *think* the population thinks. The politicians build their perception of public attitudes from the media and surveys, which are what this article is based on.

It can be concluded that the political parties' ideological backgrounds appear to have limited influence on the parties' official attitudes, and that feasibility (coalitions between parties) and support (public and professional) may play a bigger part in the decision-making context. However, the Danish tradition of the social democratic welfare state [130,132:164] might also be of importance as the difference between left and right in a Danish political context can be considered smaller than in other countries. This could explain why parties with liberal background do not propose OOP payment for GP, thus they are more social-oriented than they would be in other countries. However, it does not explain why the parties with socialist backgrounds are open for discussions of OOP payment for GP.

The application of Kingdon's theory on policy windows shows that the reason for the 'resistance' is a lack of support, which is also backed up by the advocacy coalition framework analysis that focuses on the resistance from the doctoral unions. It must also be added that the special role of the GP as a gatekeeper can influence the decision making context, as changing the financing of the GP not only influences the use of GP, but of the overall health system in Denmark. By using both frameworks, the importance of both public and doctoral (professional) support becomes evident. Specific recommendations for policy makers are therefore not to underestimate the significance of health professionals when making policies.

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References

[1] Anell A, Glenngård AH, Merkus S. Health systems in transition: Sweden. Health system review. Copenhagen: European Observatory on Health Systems and Policies; 2012.
[2] Johnsen JR. Health care systems in transition: Norway, 2006. Copenhagen: The European Observatory on Health Care Systems; 2006.
[3] Olejaz M, et al. Denmark: health system review. Health systems in transition, Copenhagen; 2012. p. 1–192.
[4] Vrangbæk K. New public management i sygehusfeltet—udformning og konsekvenser. In: Bentsen EZ, editor. Når styringsambitioner møder praksis—den svære omstilling af sygehus- og sundhedsvæsenet i Danmark og Sverige. Copenhagen: Handelshøjskolens Forlag; 1999. p. 31–56.
[5] Bolin K, et al. Utilisation of physician services in the 50+ population. The relative importance of individual versus institutional factors in 10 European countries. International Journal of Health Care Finance and Economics 2009;9:83–112.
[6] Lostao L, et al. Patient cost sharing and social inequalities in access to health care in three western European countries. Social Science & Medicine 2007;65:367–76.
[7] Lostao L, et al. Patient cost sharing and physician visits by socioeconomic position: findings in three Western European countries. Journal of Epidemiology & Community Health 2007;61:416–20.
[8] Layte R, et al. Do consultation charges deter general practitioner use among older people? Social Science & Medicine 2009;68:1432–8.
[9] Nolan A. Evaluating the impact of eligibility for free care on the use of general practitioner (GP) services: a difference-in-difference matching approach. Social Science & Medicine 2008;67:1164–72.
[10] Rosen B, et al. When co-payments for physician visits can affect supply as well as demand: findings from a natural experiment in Israel's national health insurance system. International Journal of Health Planning and Management 2011;26:e68–84.
[11] Elofsson S, Undén A-L, Krakau I. Patient charges—a hindrance to financially and psychologically disadvantage groups seeking care. Social Science & Medicine 1998;46:1375–80.
[12] Voorde CvD, Doorslaer D E.v., Schokkaert EE. Effects of cost sharing on physician utilization under favourable conditions for supplier-induced demand. Health Economics 2001;10:457–71.
[13] Cockx B, Brasseur C. The demand for physician services. Evidence from a natural experiment. Journal of Health Economics 2003;22:881–913.
[14] Krutilová V. Impact of user fees in health care system on health care consumption. Review of Economic Perspectives 2010;10:113–32.
[15] Augurzky B, Bauer TK, Schaffner S. Copayments in the German health system: does it work? Bonn: I.F.T.S.O. Labor; 2006 (IZA discussion paper no. 2290).
[16] Schreyögg J, Grabka MM. Copayments for ambulatory care in Germany: a natural experiment using a difference-in-difference approach. European Journal of Health Economics 2010;11:331–41.
[17] Rückert I-M, Böcken J, Mielck A. Are German patients burdened by the practice charge for physician visits ('Praxisgebuerh')? A cross sectional analysis of socio-economic and health related factors. BMC Health Services Research 2008;8.
[18] O'reilly D, et al. Consultation charges in Ireland deter a large proportion of patients from seeing the GP: results of a cross-sectional survey. European Journal of General Practice 2007;13:231–6.
[19] Jordin B, Engholm G. Besöksfrekvenser för unga och äldre efter införandet av avgiftsfrihet för patienter yngre än 20 år. Socialmedicinsk tidsskrift: organ för sjuk- och hälsovård 2001;1:85–90.
[20] Scott KM, Marwick JC, Crampton PR. Utilization of general practitioner services in New Zealand and its relationship with income, ethnicity and government subsidy. Health Services Management Research 2003;16:45–55.
[21] Zápal J. Doctor-visit co-payment exemption for children: first look at the data. Czech Journal of Economics and Finance 2010;60:58–72.
[22] Kingdon J. Agendas, Alternatives and Public Policies. Boston: Little Brown & Co.; 1984.
[23] Heintz HT, Jenkins-Smith HC. Advocacy coalitions and the practice of policy analysis. Policy Sciences 1988;21(2):263–77.
[24] Sabatier PA. An advocacy coalition framework of policy change and the role of policy-oriented learning therein. Policy Sciences 1988;21(2):129–68.
[25] Køhler Thomas. Information, Debat: 40 pct. i skat. Information 2010.
[26] Nielsen Hanne Fall. R og K: Husk pungen ved lægebesøg. Jyllands-Posten 2011.
[27] Rasmussen Rikke. Venstres landsmøde: vi har mistet grebet. Ekstra-Bladet 2006.

[28] Drevsfeldt Sabrina. Brugerbetaling Brugerbetaling skal bredes ud på flere forskellige sundhedsydelser. Information 2009.
[29] Ledende artikel Politiken, Dogmatisk modstand, Politiken, 2011.
[30] Dahl Jonas. Nyt fra bloggen. Ugeskrift for læger 2011.
[31] Ole Nikolaj Møbjerg Toft. Sundhed—speciallæger positive over for brugerbetaling. Altinget 2012.
[32] Bjørnager Jens Anton, Nielsen Michael K, Gudmundsen Sune, Møller Nynne Hein. Enige politikere: brugerbetalingen er ulogisk: det er ikke særlig logisk men det er nu en gang sådan det er. Berlingske-Tidende 2012.
[33] Rosenkrantz-Theil Pernille. Vi dødelige har brug for gratis lægehjælp. Ekstra-Bladet 2008.
[34] Olsen Lars. Vi fik ændret systemet. Aktuelt 1999.
[35] Langager Morten. Nok for pengene?: nej til brugerbetaling. Jyllands-Posten 2001.
[36] Ritzau. S. Betaling for lægebesøg. Politiken 2005.
[37] Borg Orla, Pihl-Andersen Axel. Danskere åbner for brugerbetaling. Jyllands-Posten 2011.
[38] Steenberger Anne. Kortnyt. Ugeskrift-for-læger 2006.
[39] Jensen Martin Kjær. Lægegebyr kan spare milliarder. BT 2012.
[40] Christiansen Flemming. Gebyr hos lægen. Politiken 1995.
[41] Holstein Erik, Nielsen Tenna. Du skal betale 75 kroner for at besøge lægen. BT 1995.
[42] Kjær Esben. Død over velfærdssamfundets hellige køer. Politiken 2008.
[43] Førende sundhedsekspert: indfør brugerbetaling på lægebesøg, Mandag Morgen, 2010.
[44] Andersen Torben K. Betal for at gå til læge. Aktuelt 1999.
[45] Møller Lone. Debat jeg tør godt drøfte brugerbetaling. BT 2006.
[46] Borg Orla, Pihl-Andersen Axel. Opgør med gratis besøg hos lægen. Jyllands-Posten 2008.
[47] S-folk foreslår: 300 kr. for at gå til lægen, BT, 2012.
[48] Kirkbak Jesper. Eksperter roser Barfoed: god ide. BT 2011.
[49] Børsting Mikael, Klingsey Mette. Velfærdsopgør V-folk kræver brugerbetaling. Information 2006.
[50] Grund Jens, Pihl-Andersen Axel. Nok for pengene?: forslag: betaling hos lægen. Jyllands-Posten 2001.
[51] Larsen Klaus. Nyheder eksminister undsiger VK's behandlingsgaranti. Ugeskrift-for-læger 2010.
[52] Pedersen Flemming Steen. Brugerbetaling: OECD. Vi skal betale for lægebesøg. Berlingske Tidende 2008.
[53] Jessen Christian. Det umenneskelige valg. Berlingske Tidende 1998.
[54] Ehrenskjöld Christina, Rytter Sophie Jo, Quist Sverre. Det vil vi med velfærden. Ekstra-Bladet 2010.
[55] Møbjerg Ole Nikolaj. Eks-sundhedsminister ser tilbage. Altinget 2010.
[56] Ledende artikel: Fy-ordet, Information, 2008.
[57] Borg Orla, Pihl-Andersen Axel. Pro/kontra. Skal vi selv betale til et besøg hos lægen? Jyllands-Posten 2008.
[58] Parliament. B 87 forslag til folketingsbeslutning om nedsættelse af et ekspertudvalg, der skal analysere brugerbetalingen på sundhedsområdet med henblik på en omlægning; 2007.
[59] Krohn Ole, Andersen Torben K. 100 kr. for at gå til sin læge. Aktuelt 1996.
[60] Billet til lægen, BT, 1996.
[61] Dibbern Henrik. Debat: lægebesøg. Brugebetaling er ikke vejen frem. Politiken 2011.
[62] Winckler Poul. Brugerbetaling—nytter det noget? Aktuelt 1999.
[63] Kirkbak Jesper. K. Lægebesøg skal koste. BT 2011.
[64] Klingsey Mette. Brugerbetaling: venstrefolk åbner for brugerbetaling. Information 2008.
[65] Egenbetaling: sundhedsøkonom god fornuft i S forslag, Information, 2005.
[66] Nielsen Katrine. Loft over sundhedens pris. Aktuelt 1998.
[67] Rasmussen Peter, Fleckner Mette. Betal selv lægen. Ekstra-Bladet 1995.
[68] Andersen Torben M. Kronik kan brugerbetaling lette vores velfærdskvaler? Information 2012.
[69] Gudmundsson Sune, Møller Nynne Hein, Nielsen Michael Korsgaard, Bjørnager Jens Anton. Eksperter efterlyser opgør med vilkårlig brugerbetaling. Berlingske 2012.
[70] Andersen Torben K. Amter vil øge brugerbetaling på sygehusene. Aktuelt 1998.
[71] Nielsen Katrine. Når borgeren betaler bliver borgmesteren klogere. Aktuelt 1998.
[72] Ole Nikolaj Møbjerg Toft. Sundhed—R: brugerbetaling skal være logisk og retfærdig. Altinget 2012.
[73] Radikale. Vores ide den mest retfærdige, Ekstra-Bladet, 2012.
[74] Ditlev Niels. Betaling støtte til brugerbetaling. Jyllands-Posten 2006.
[75] Nielsen Hanne Fall. Brugerbetaling hos lægen. Politiken 1998.
[76] Ellegaard Carsten. Brugerbetaling flertal for en sundhedskommission. Jyllands-Posten 2000.
[77] Beder Charlotte, Nielsen Hanne Fall. Hvordan betaler vi den voksende regning? Jyllands-Posten 2009.
[78] Knud Brix, Boddum Dorte Ipsen. V-profiler kræver mere brugerbetaling. Jyllands-Posten 2011.
[79] Ledende artikel: Opgør med et dogme, Kristeligt Dagblad, 2010.
[80] Dørge Henrik. Op af lommen. Weekend-avisen 2006.
[81] Den ulogiske sundhed, Berlingske-Tidende, 2012.
[82] Opgør om brugerbetaling, Jyllands-Posten, 2002.
[83] Aarsland Line. Offentlig service: sådan vil VK gøre os mere tilfredse. Politiken 2012.
[84] Kaae Martin. Regioner Vi skal bruge 2 milliarder mere i 2011. Politiken 2010.
[85] Juhl Line Vaaben, Møller Erik Bjørn. Brugerbetaling skal drøftes med minister. Berlingske-Tidende 1998.
[86] Middelboe Poul. Debat genoptages. Berlingske-Tidende 1995.
[87] Madsen Jens Jørgen. K vil undersøge brugerbetaling. Berlingske-Tidende 2000.
[88] Thobo-Carlsen Jesper. Patienters betaling skal kulegraves. Berlingske-Tidende 2002.
[89] Parliament. B 36 Forslag til folketingsbeslutning om en national strategi for bekæmpelse af uligheden i sundheden; 2006.
[90] Andersen Ida Damgaard. Læger advarer mod stigende brugerbetaling. Information 1999.
[91] Grund Jens, Pihl-Andersen Axel. Nok for pengene? sygemelding. Jyllands-posten 2011.
[92] Brugerbetaling for besøg hos læge, Kristeligt Dagblad, 2009.
[93] Rudbeck B, et al. Brugerbetaling i Sundhedsvæsenet. Kortlægning og analyse. Copenhagen: Dansk Sygehus Insitut; 1995.
[94] Velfærdskommisionen. Fremtidens velfærd—vores valg. Copenhagen: Velfærdskommisionen; 2005.
[95] OECD. Economic survey of Denmark 2008. OECD; 2008.
[96] Kiil A, Houlberg K. Adfærdsmæssige effekter af brugerbetaling: En systematisk forskningsgennemgang af danske og internationale undersøgelser på sundheds- og ældreområdet fra 1990–2011. Copenhagen: AKF, Anvendt KommunalForskning; 2012. p. 1–69.
[97] Gudmundsson Sune. 4 skarpe: Astrid Krag (SF), Sundhedsminister. Berlingske 2012.
[98] Parliament. B 36 Forslag til folketingsbeslutning om en national stategi for bekæmpelse af uligheden i sundheden; 2005.
[99] Ledende artikel, Angreb på hellig ko, Jyllands-Posten, 2001.
[100] Debat Velfærd og sundhed (1): Væk med automatpistolen!, Politiken, 2008.
[101] Skovmand Kaare. Den tilfældige brugerbetaling. Politiken 1997.
[102] Ledende artikel: Brugerbetaling, Politiken, 2002.
[103] Pihl-Andersen Axel. Brugerbetaling—et fy-ord. Jyllands-Posten 2006.
[104] Debat: Brugerbetaling Fjeren blev til fem høns i sundhedsdebatten, Politiken, 2006.
[105] Ubrugelig debat om brugerbetaling, Berlingske Tidende, 2006.
[106] Sygeplejersker i ny lønkamp, Politiken, 2008.
[107] Bundgaard Bente. Nyheder Fem spørgsmål til Vivi Kier, sundhedsordfører, Det Konservative Folkeparti. Ugeskrift-for-læger 2011.
[108] Dahl Ann-Sofie. Gør som svenskerne: Indfør sundhedsgebyr. Berlingske Tidende 2011.
[109] Pedersen Christina C. Mindre velfærd til de rige. BT 2012.
[110] Grund Jens, Pihl-Andersen Axel. Brugerbetaling: Professor Bange politikere. Jyllands-Posten 2001.
[111] Clausen Sejr. Læger advarer mod betaling for lægebesøg. Berlingske Tidende 1995.
[112] Hoffmann Thomas, Olsson Kristina. Lægebesøg har social slagside. Politiken 2002.
[113] Grund Jens. Sundhed Patientforeninger imod brugerbetaling. Jyllands-Posten 2005.
[114] Ledende artikel: Lægeoprør, Politiken, 1991, Redaktionen.
[115] Bové Troels. Debat: Brugeretaling Et svært valg. Politiken 2002.
[116] Bundgaard Bente. Kort nyt: Ind- og udland. Ugeskrift-for-laeger 2005.
[117] Dibbern Henrik. Sundhed—Styrk det nære sundhedstilbud. Altinget 2011.
[118] Pedersen Torpen. Lægen med sparekniven. Politiken 1995.
[119] Ldende artikel: Lægeoprør, Politiken, 1991.
[120] Ole Nikolaj Møbjerg Toft. Sundhed—EL-ordfører vil pill i akutplaner. Altinget 2011.

[121] Ole Nikolaj Møbjerg Toft. Brugerbetaling og reformer. Altinget 2012.
[122] Sørensen Manja. Svenskerne betaler hos lægen. Aktuelt 1996.
[123] Mølgaard Mikael, Christiansen Jens. Vi forsvarer os med sygeforsikringer. Aktuelt 1998.
[124] Pedersen Flemming Steen. Brugerbetaling—et politik minefelt. Berlingske-Tidende 2003.
[125] Olsen Las. Kan vi ikke bare betale selv? Berlingske-Tidende 2005.
[126] Pedersen Flemming Steen. R. åbne over for brugerbetaling. Berlingske-Tidende 1999.
[127] Grund Jens, Langager Morten. Sundheds-væsenet. Brugerbetaling? Nej tak!: interview: Arne Rolighed. Jyllands-Posten 2001.
[128] Velfærd: Kapitel 5. Et samfund med tidssvarende velfærdsservice, Politiken, 2005.
[129] Geckler S, Hansen H. Brugerbetaling på velfærdsydelser—smart fix eller nødløsning? Copenhagen: CASA (Center for Alternativ Samfundsanalyse); 2011.
[130] Vallgårda S. Sundhedsvæsener—centrale begreber og definitioner. In: Vallgårda S, Krasnik A, editors. Sundhedsvæsen og sundhedspolitik. Viborg: Munksgaard Danmark; 2010.
[131] Esping-Andersen G. Three worlds of welfare capitalism. In: Pierson C, Castles FG, editors. The welfare state reader. Cambridge: Polity; 2006.